Erin LeVan M.Ed, LMHC, NCC, CMHS
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Spokane Valley, WA 99206
509-953-5134

Counseling Questionnaire

Referral Source:____Today's Date________

Patient Name:_____________________________________Date of Birth____________

Age_________ SSN_______________ Sex **Male Female**

Address/street___________________________City_________________Zip__________

Phone: ___________________Employer/School______________________________

Email____

If Patient is a Child

Mothers Name:_____________________DOB____________SSN_______________

Employer___________________ Email____________________________________

Home #__________Ok call Y/N Cell #_________Ok call Y/NO Work #__________Ok call Y/N

Father's Name___________________DOB_____________ SSN____________

Employer _________________Email____

Home #__________Ok call Y/N Cell #_________Ok call Y/NO Work #__________Ok call Y/N

Sibling(s) of Patient if child (include name age/DOB) ____________________________________

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Insurance Information

Primary Insurance Name:______________________ Secondary Ins. Name_________________

Subscriber Name_____________________________ Subscriber Name_____________________

*I understand that **Erin LeVan** and/or her billing providers will attempt to verify insurance coverage, but that verification does not guarantee payment. My insurance carrier at any time refuse to pay any part or all of the charges despite verification, I further understand that I am fully responsible for payment of the services provided.*

*I hereby authorize payment made directly to **Erin LeVan,** for the benefits otherwise payable to me but not to exceed the provider's regular charges for the services provided. I understand that I remain financially responsible to the provider for all charges that incur.*

Signature____ Date_______________________

What have you or your family experienced that brings you to seek counseling?

1. What behaviors, challenges or emotions are most challenging around the above mentioned experience (s)?

2. Please note any medical care providers/physicians that you are currently involved with and any medical issues/concerns such as allergies, illnesses or accidents.

3. Are you or the consumer you are seeking counseling for on any medications? If Yes please list these medications, the dosage, frequency and who is prescribing the medication.

4. Do you have any past or present legal history, issues or concerns?
   Yes_____ No_______
   If yes please list these.

5. Do you or any family members have a current or past history of substance abuse?
   Yes______ No________
   If yes, please note any history for self or others, drug of choice, first use and length of use and if treatment for this was sought.

6. Have you ever been involved in past or current counseling or been hospitalized?
   Yes________ No_________
   If yes, please note name of provider/hospital, dates and service provided.

7. Why are you coming to therapy now?

8. Emergency contact information (name, relationship and phone number) _______

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9. Are you feeling that you or the patient is at risk of Harming self or others? If yes please describe.

10. Please comment on any other information that might be important for your Counselor to be aware of.